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Dangers and Complications of Uterine Fibroids

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DANGERS AND COMPLICATIONS OF UTERINE FIBROIDS.[1]

THE many articles written and published within the past few years upon the various methods of performing hysterectomy for uterine fibroids, indicate that the profession is fast awaking to the fact that these growths are not the simple, inoffensive, uncomplicated neoplasms that we were taught to believe in our early professional life. We were taught that they were comparatively harmless during menstrual life, were generally absorbed after the menopause; so that he who even suggested any surgical interference, especially hysterectomy, would have been severely criticised by the conservative, judicious members of the profession. In fact, within the past year one of our ablest medical journals has indulged in a most sarcastic editorial against those surgeons and gynecologists who have been most forward in urging operations for removal of the uterus when so affected. Nevertheless the work goes on and the "world moves." Hysterectomy is being performed every day, and the mortality is not any greater than that from ovariotomy ten years ago. The "conservative" man may say that this is far too large for a disease that is attended with so little danger to life as the one under consideration. In reply it may be said that death is not the only phase of the matter to be considered. Physical suffering and chronic invalidism far outweigh the other factor. This latter condition has not, in my opinion, been fully appreciated by the profession generally. The literature is very meagre on this point, and the observers have not published the results of their observations.

One year ago I read a short paper before the American Medical Association (Section on Obstetrics and Diseases of Women), in which I claimed that hysterectomy for uterine fibroids "is the only proper conservative surgery, and that it can be made equally safe with that of ovariotomy at the present day." In

[1] Read at the eighteenth annual meeting of the American Gynecological Society.

the course of the discussion I found but one or two who were favorable to this presentation of the case, while the general tenor of the arguments was that only in a comparatively few cases were such radical measures justifiable, inasmuch as the mortality and suffering were so very insignificant when the cases are left to run their course.

My own observations up to that time had shown me many cases of death from this cause, and untold suffering added to wretched, useless lives. Within the past year I have more carefully kept notes and records of the cases upon which I have operated, and that have otherwise consulted me, with the view of presenting the prominent features of the worst cases.

The great aim of the profession should be to give the greatest good to the greatest number, and I submit the question whether the mortality of ten or even fifteen per cent should deter us from operating where such undoubted good results are accomplished as in hysterectomy—results that are superior to those found after ovariotomy and oöphorectomy, and for obvious reasons: viz., the entire genitalia are removed, and no further trouble is expected, as happens frequently where a heavy, hyperplastic, displaced uterus remains.

I fully believe if it were the rule that in every case of fibroid of the uterus we made hysterectomy before the patient was exhausted by hemorrhages, peritonitis, salpingitis, and consequent invalidism—in short, if we operated upon all cases in the early stages, as we all advise now for cystoma of the ovary—that our mortality would be no greater, and at the end of a year we would have a much greater sum of human happiness and relief to physical suffering. "It is not all of life to *live*, nor all of death to *die*," when *dying* ends years of agony, mental and physical. The patient and friends demand relief from us, and if we offer that which in a very large percentage of cases gives it, they are willing to accept the risk rather than bear the "ills they have."

The most conservative in the profession are well agreed that we should make hysterectomy, in rapidly growing fibroids at or near, and especially after, the menopause, for excessive bleeding that cannot be controlled by ordinary means, for repeated attacks of peritonitis caused by pressure, for pyosalpinx or other severe forms of salpingitis, for sarcomatous, carcinomatous, calcareous, or cystic degenerations of the fibroid. These same

"conservative" men deplore that the operation could not have been made earlier, knowing that the chances for the best success have been lost by delay; and yet the very next case that they see in which no complications exist they very gravely advise waiting till they do exist. The "jewel of consistency" does not seem very brilliant, to my limited vision, in such advice. It certainly is not "for this we are doctors." I am sure that if the profession can become well satisfied that danger lies in delay, that there are a sufficient number of these complications to offset the dangers from hysterectomy, they are only too willing to advise that which offers, on the whole, the greatest good. But, at the same time, I insist that mortality from hysterectomy shall not be the only element to be considered in deciding for or against an operation. Physical suffering is a large factor with the patient, and I repeat that she is more than ready to take her part of the risk for the hope that lies beyond. When you add to the physical suffering the mortality of fibroids left to their natural course, I think we have a large preponderance of testimony in favor of the operation. I venture the assertion that the deaths from this cause will fully equal that from operating, provided all cases are operated upon as early as I advocate. We have left, then, in favor of surgical interference the relief and cure of this immense factor—years of suffering and invalidism.

Among the cases of complication that I have observed are the following: Prior to the past year sarcomatous degeneration of a large fibroid, apparently commencing in the centre; this I have found in not less than three cases. One case calcareous degeneration; in this case I made Hegar's operation, removing the appendages from each side, which stopped the growth; but, as it did not absorb, at the end of two years it was so painful through the pelvis that I made hysterectomy, and found the whole mass so completely calcareous that I was obliged to use a saw to make a section. She made a good recovery and has since been a healthy woman, while for at least ten years before she had been entirely unable to do her housework. I have seen but one fibro-cyst in my own practice, but have seen two or three in consultation. A recent case of sarcomatous degeneration of a fibroid came under my observation at the Maine General Hospital. The patient died after operation, from the destruction consequent upon the malignant degeneration, adhesions, etc.

One case where softening occurred in an enormous fibroid, from which two others grew very rapidly; beneath the whole mass was an intraligamentous cyst of each ovary. The suffering was so great that I attempted operation, but she died from shock and hemorrhage within a few hours. Dr. Homans saw this case in consultation and believed operation justifiable. Had she been operated on when I first saw her five years before, I have no doubt as to the result.

Within the past year I have made as many as twenty hysterectomies for various purposes, mostly fibroids. Four cases have died. One was an epileptic. One had malignant sarcomatous degeneration. A third had suffered from repeated attacks of peritonitis and terrible floodings, for which I had curetted with only temporary relief; the adhesions were very extensive, and the whole mass made up of a large number of very hard, nodular fibroids. Fourth case, interstitial fibroid, uterus bound down by adhesions; had severe hemorrhage from vagina soon after operation, and died three days after. In no one of the cases of death was there simple, uncomplicated fibroid. A very frequent complication was cystic ovaries, and in quite a large percentage I found pyosalpinx, and abscess of ovary in several.

In nearly every one of the twenty cases there was some complication that was an element of danger to life or delayed operation and prolonged recovery. Had operation been made early all this could have been saved. All of these women had been invalids for years, and, to use their own expression, had arrived at that point where "life is a burden."

In some of the cases the tumors began a rapid growth after menopause. One case in particular I had watched for several years, had curetted twice for hemorrhages, but the tumor did not increase much in size until the menopause was completely established. Within one year after, the tumor increased to double its size. The pain and discomfort increased and she insisted upon operation. Her recovery was complete.

The operation that I make is a simple one, mostly by suture with catgut, ligating the broad ligament beneath the Fallopian tube close to the uterus with silk, then with a strong catgut suture at a point an inch outside, cutting and sewing over and over the broad ligament down each side until the uterine artery is reached, when I dissect off the peritoneum in front and

behind until I enucleate the cervix. I then close the peritoneal flaps. No drainage.

Conclusions.—1. Uterine fibroids are always more or less troublesome, and in a large majority of cases produce a state of chronic invalidism.

2. In a large percentage of cases they are complicated with excessive hemorrhages, peritonitis, salpingitis, and ovaritis, with purulent collections and adhesions, producing continual suffering.

3. Many of them do not cease growing at the menopause, but increase.

4. Many undergo degeneration, either calcareous, cystic, or malignant.

5. Hysterectomy is not a very dangerous operation if made in the early history of the case—no more so than ovariotomy.

6. In addition to the saving of life, it relieves (in nearly all the cases) the woman from a life of invalidism.

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